

Licensed to Kill – The Impact of Legalising Euthanasia and Physician Assisted Suicide on the Training of UK Medical Students

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ABSTRACT

There have been a number of attempts to legalise euthanasia and physician assisted suicide (PAS) in the UK over the past decade. The potential impact of legalising euthanasia and PAS in the UK on the training of medical students, the next generation of doctors, is examined in this discussion paper.

Key Words: euthanasia, assisted suicide, medical students, education

Introduction

The terms used in the euthanasia debate are often confusing. We include the following definitions in Table 1.

Table 1 - Definitions⁽¹⁾

Euthanasia	Translated literally from Greek to mean 'good death'. Commonly referred to as 'mercy killing'.
Active Euthanasia	Intentional administration of lethal substances to hasten death.
Voluntary Euthanasia	Euthanasia performed with informed consent from a competent person or by instruction of an advance directive
Involuntary Euthanasia	Euthanasia performed without consent.
Physician Assisted Suicide	A doctor assists another person to end his or her life e.g. by prescription of lethal drugs.

The debate surrounding the legalisation of euthanasia and physician-assisted suicide has become polarised. The principal arguments “for” and “against” euthanasia and PAS are well documented and will not be reiterated here.^(2,3)

Most people assume that if euthanasia and PAS are legalised, it will be doctors who will be prescribing the lethal medication or, in euthanasia, administering it.⁽⁴⁾ Thus it is of particular importance that medical students and doctors express their views on this contentious issue that could have an enormous impact on their clinical practice. This discussion paper examines the impact of legalising euthanasia and PAS in the UK on the training of medical students, the next generation of doctors.

Legal Background

There have been a number of attempts to legalise euthanasia and physician assisted suicide (PAS) in the UK. The present law strikes a balance by providing safeguards for the vulnerable and compassion for individual, extreme ‘hard’ cases.

2003 Lord Joffe proposed the Assisted Dying Bill which would have legalised both euthanasia and PAS but it failed to progress.

2004 Lord Joffe introduced another Bill (Assisted Dying for the Terminally Ill). It was referred to a House of Lords Select Committee.

2005 House of Lords Select Committee chaired by Lord Mackay of Clashfern spent six months meticulously reviewing the evidence on the legalisation of euthanasia and assisted suicide. The committee failed to reach a consensus but did agree recommendations that any future legislation should take into account.⁽⁵⁾

2005 Lord Joffe presented his third Bill that now was limited to assisted suicide. It was defeated in the House of Lords by 148 votes to 100.

2005 Jeremy Purvis MSP presented a consultation paper to the Scottish Parliament, “Dying with dignity”. This failed to achieve sufficient support to generate a full debate.

2009 Lord Falconer’s proposed amendment to the Coroner’s and Justice Bill, designed to remove the risk of prosecution from those taking their relatives to a country where assisted suicide was lawful, was defeated by 194 votes to 141.

2009 Law Lords unanimously agreed that Debbie Purdy had the right to know whether her partner would face prosecution if he helped her to end her life. The Law Lords instructed the Director of Public Prosecutions (DPP), Keir Starmer QC, to publish prosecution policy relating to cases of assisted suicide.

2010 The DPP “Policy for Prosecutors in respect of cases of Encouraging or Assisting Suicide” was more focussed on the motives of the suspect rather than the characteristics of the victim. Starmer made clear that the policy did not change the law on assisted suicide nor open the door for euthanasia.⁽⁶⁾

2010 Margo MacDonald’s ‘End of Life Assistance Bill’, which allowed both euthanasia and PAS, was defeated in Scottish Parliament by 85-16.⁽⁷⁾

Current training for medical students

The General Medical Council (GMC) in the UK has given a clear recommendation in *Tomorrow's Doctors* that all medical students should receive core teaching on caring for the terminally ill.⁽⁸⁾ At present, provision of teaching on end of life care varies greatly from one university to another. It has been suggested that UK medical students have higher levels of awareness of palliative medicine than their US colleagues and that they have a more positive approach towards its role⁽⁹⁾. Legalisation of euthanasia would undermine this progress.

Competition for undergraduate teaching time is fierce, and the new teaching would, at the very least, have to cover the following areas;

- the assessment of the euthanasia request
- attitudes to dignity
- the practicalities of ending life
- support of the family
- self-support
- support of colleagues

The undergraduate curriculum is already overloaded and it is possible that aspects of palliative care teaching would be sacrificed to make way for teaching on how best to end the life of patients.

Doctors in the UK have little knowledge of how patients could be euthanized and so far have never had to consider this on a practical level. Furthermore, the majority of doctors involved in end of life care want no part in this process.⁽¹⁰⁾ Perhaps if euthanasia and assisted suicide were legalised they should not be regarded as part of a doctor's duty but instead be administered by lawyers and technicians trained to carry out euthanasia and assisted suicide⁽⁴⁾.

Role contradiction

The Hippocratic injunction "first do no harm" is a cornerstone of the healthcare professional's duty of care, a duty which legalisation of euthanasia would overturn so that the patient's life could be ended. The importance of this paradigm shift in medical practice should not be underestimated. It would require a new ethos in medicine.

Students would require support to cope with the stresses involved in making decisions about euthanasia and assisted suicide⁽¹¹⁾. A number of students may be conscientious objectors to euthanasia and PAS. Recruitment and selection of undergraduates might be affected if euthanasia was legal in the UK. There have been no published large-scale surveys of UK medical students' views on euthanasia and PAS.

Trust

Euthanasia legislation has the potential to affect the trust between the student/doctor and patient (Figure 1). Such trust is essential for medical care. The present law recognises this and protects patients and society by making it clear that doctors are not permitted to intentionally end a patient's life or to assist in their suicide but rather they have a duty of care to act in the patient's best interests until the end of their natural lives. However, once euthanasia and assisted suicide become legitimate 'treatments', doctors would be obliged to raise them as options with all dying patients. Such conversations would be bound to raise fears in some patients that the doctor had an interest in hastening their death.



Fig 1- Euthanasia legislation has the potential to affect the trust between the student and patient.

Value of life

The legalisation of euthanasia and PAS makes an underlying assumption that the worth of human life depends on features such as physical or mental ability, rather than being valuable in itself. Such legislation would send a message to people with disabilities or any chronic disease that because they are dependent on others they might reasonably consider their lives to be less worth living than those of their peers. Consequently they may feel obliged to choose euthanasia or assisted suicide in part because society tells them they are less valuable than others. Teaching students to carry out the task of judging whether life is 'tolerable' or 'worth living', goes against the current medical ethos and could inhibit patients from disclosing their concerns about physical, social, psychological or spiritual distress. Since it is often possible to resolve underlying issues that ultimately lead to suicidal desires, it is crucial that patients feel able to communicate openly with students and doctors.

Dignity and Choice

Choice is only one aspect of autonomy, but autonomy should not be confused with independence. We are dependent upon others for our existence throughout our lives and so dependence is an integral part of what it is to be an autonomous human being. Our mutual dependence is a part of our human dignity⁽¹²⁾. Such a concept of human dignity is devalued by equating it with euthanasia or PAS.

Patient dignity is already threatened at times in hospital where there is often a lack of privacy for patients. Euthanasia would be an extremely sensitive topic to discuss

behind curtains with the rest of the ward listening. It would distress neighbouring patients, and it is even possible that patients would be moved into a hospice. Hospices in the UK are places where patients place great faith and trust in their doctors and nurses, and PAS or euthanasia would change this therapeutic dynamic. Already many patients are apprehensive about coming to a hospice and legalisation of euthanasia and PAS would tip the balance even further in a negative direction.

Practicalities

It is often assumed that all euthanasia and assisted suicide deaths are peaceful and therefore “dignified”. Students may fail to take account of the complications that can occur in the process of assisted suicide and euthanasia. In a Dutch study, 3-16% of patients who had either euthanasia or assisted suicide had complications such as failure of completion, myoclonus or vomiting ⁽¹³⁾. Students would need instruction on how best to end a patient’s life. Practical skills in ending life would need to be tested and assessed. Training would need to be provided in developing the necessary communication skills to respond to the patient’s plea “Please help me to die!”

Responding to a request for euthanasia

Individual requests for euthanasia and physician-assisted suicide are complex in origin and demand careful attention with open and sensitive communication. Patients and families often experience great difficulty in discussing death and dying, how much more difficult it would be to discuss euthanasia and suicide. Sensitive exploration of the euthanasia request can help to identify the real needs of an individual patient. The request for euthanasia or physician-assisted suicide seems to point to a series of concerns that the patient has about dying; relating to loss of self, loss of dignity and the social context of dying. Understanding these concerns may help to improve the care of dying patients.

However, assessment of the euthanasia request can also create a barrier which subtly alters the doctor-patient relationship and may paradoxically impair the possibility of discussing the patient’s hopes and fears. Sometimes it can be difficult to assess a patient’s needs when the goal of euthanasia dominates the discussion.

At present, when faced with a patient saying that ‘life is not worth living’, medical students are taught to acknowledge the patient’s distress and then make an effort to address the factors underlying these feelings. This approach demonstrates that the patient is valuable in themselves and that the value of their life is not diminished by their loss of independence or disability. If euthanasia and PAS were legalised then an alternative approach becomes possible; where the doctor agrees that the patient’s life is intolerable and deliberately hastens their death. This confirms to patients that their lives really have lost meaning and purpose, not only in their own eyes but in the opinion of others and society at large. Legal endorsement of this approach teaches students and doctors, not only that there exists a category of people whose lives are not worth living, but also that it is proper for doctors to make judgements about who might be included in this group. Legalisation of euthanasia will encourage

medical decisions that lead to its use rather than the current practice of addressing the causes of despair.

A change of mind

Patients often change their minds about their initial euthanasia request. In the quest for patient contact, medical students often have more time to listen to patients and in turn patients may reveal more to an individual student than they necessarily would to a ward round team. Would a sad expression or a throwaway remark qualify as a sign that the patient does not want to end their life? What would a student do in such a situation and what would be the implications if the student's impression was not taken seriously by senior medical staff?

Wider impact

Legislation will change the way in which society views the sick, the disabled and the dying. There is a danger that such patients will be seen as an inconvenience to be disposed of. Patients might feel a burden to their families and society and so feel obliged to consider euthanasia. There is much for students to learn about the importance of a patient's social circumstances in generating a request for euthanasia or assisted suicide⁽¹⁴⁾. Rather than encouraging society to develop measures to address the suffering of patients, which affirms their intrinsic worth, legislation will encourage the attitude that human dependence and need actually devalue human life.

Role of Palliative care

Clinical experience shows that with the proper provision of palliative care services, and adequate and timely access to practical and necessary support for patients and their family, persistent requests for euthanasia are infrequent. Where they do exist, the solution lies in providing support and the best possible care to engage with issues such as hopelessness and suffering, not in euthanasia or physician assisted suicide. It is imperative that patients, their families and the public are clear that palliative care is fundamentally different from euthanasia and physician-assisted suicide.

Conclusion- A medical student's view

When applying for a place in medical school we were filled with the hope of curing disease and alleviating suffering. These basic, humanistic ideas formed the basis for our career choice and hopefully will still be at the core of our clinical practice beyond graduation. If the above legislation had passed before I applied to medical school, and I had known that my future would include euthanizing patients this would have made me seriously question the fundamental principles of medicine. I wonder if, as a consequence of this legislation, Medicine would attract a different group of applicants; those who do not say at their interview, "I want to help people" but instead say, "I want to help people to die."

Recent evidence suggested that the UK's foundation doctors are inadequately prepared for dealing with dying patients on the wards ⁽¹⁵⁾. The study noted a tendency for medical students to shy away from encounters with the dying and an overall lack of undergraduate exposure to this patient group. In the era of 'modern medicine' we are still notoriously uncomfortable with patients who die as a consequence of disease progression; we are uncomfortable with natural law. Bearing this in mind, it is concerning to think that Parliament has repeatedly come so close to passing a law which would necessitate student attendance of compulsory sessions to educate us on the clinical 'skill' of assisting suicide. Student lectures would include the theory of euthanasia and provide instructions in humane methods that could be employed to end a human life. Communication skills sessions would involve counselling simulated patients on how we could hasten their death.

We are nowhere near being able to say we have mastered the art of palliative care, much of which is simply good care, much less being able to say we have overcome the need for it.

Politicians will continue to debate the theoretical and ethical issues surrounding euthanasia and PAS, but they will not be the ones offering euthanasia as a treatment option to patients. They will not be sitting by a patient's bedside with their thumb on a lethal syringe. They will not go home at night knowing that a patient's death was hastened on their watch. They will not have to live with the burden of these thoughts for the rest of their lives.⁽¹⁶⁾

We paint this picture not to enforce our views upon others but to encourage students to consider the practical implications of PAS or euthanasia legislation on our future professional and personal lives. Medical students are currently able to openly debate issues such as euthanasia and are still free to voice their opinions without legislation demanding competencies in PAS or euthanasia before or during foundation years. It is imperative that we do voice our opinions. This is said in multiple ethics articles and teaching sessions, but it is not simply to show that we are brave enough to have opinions on job application forms. Our voices are those of the next generation of doctors and will have an impact on future patient care.

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